Return to: City of Long Beach
Dept. of Human Resources & Affirmative Action
333 W. Ocean Blvd., 13th Floor
Long Beach, CA 90802

Statement of Claim — In-Hospital Indemnity

PART A

Employee's Statement

Attach Copy of hospital bill

1. Employee's Name _____ Age _____
2. Address _____
   Street and Number City State Zip
3. Social Security Number _____
4. If claim is for an eligible Dependent complete this section.

   Name of Dependent: _____ Birthdate ___/___/___

   Relationship: _____

   Social Security Number _____

   If Student age 19 to 25:

   a. Name of school: _____

   b. Course of study: _____ Number of current units _____

5. Do you or does your dependent intend to present a claim for Workmen's Compensation arising out of this disability?

   _____

6. I certify that the above answers are true and complete to the best of my knowledge and belief.

   Signed _____ Signed _____
   Insured Employee Dependent if patient and not a minor

   Date ___/___/___

PART B

Physician's Statement

1. Name of Patient _____ Age _____
2. Diagnosis of Record _____
3. Has Patient ever had same or similar condition? ☐ YES ☐ NO

   If yes, date of previous treatment _____
4. Is Disability due to patient's occupation? _____
5. Date of hospital admission _____ Date discharged _____
6. Name of Physician _____
   Please Print

Signature _____ Date ___/___/___

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